

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1903	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2011
NAME OF PROVIDER OR SUPPLIER BETHANY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 421 OCALA DRIVE NASHVILLE, TN 37211			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure survey conducted on February 22, 2011 through February 24, 2011, at Bethany Health Care Center, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0899

R0QE11

TITLE

ADMINISTRATOR

(X6) DATE

4-4-2011

If continuation sheet 1 of 1

MAR 08 2011